

# 2021 Summary of Benefits



Our service area includes the following county in FL: Broward.

# Benefits at a glance

Premiums and Deductibles

**\$0**

Primary Care Physician (PCP) visits

Specialist visits

Inpatient Hospital with unlimited days

Urgent Care

Labs

Supplemental Coverage, including

No dollar limit on covered preventive and comprehensive dental

\$300 for eyewear

\$2,000 for 2 hearing aids

\$100 for over-the-counter items every 3 months

Silver & Fit gym access or FitBit kit

Post discharge meals

Virtual Urgent Care telehealth services

Unlimited one-way transportation trips

Tier 1 AND Tier 2 drugs

Erectile Dysfunction drugs (6 pills every 30 days)

**\$0 copay**

**No referrals** needed to see in network providers

# Welcome to Oscar.

Oscar, Holy Cross Hospital, and Memorial Healthcare System have partnered to offer a new Medicare Advantage plan that combines Holy Cross Hospital and Memorial Healthcare System's best in class state of the art healthcare with Oscar's member Care Team services for more accessible, personalized care. We are working together to better serve Medicare patients through high-quality care at more affordable costs.

The benefit information provided in this book is for January 1, 2021 through December 31, 2021 and does not list every service that we cover or list every limitation or exclusion. To get a complete list of services this plan covers, please call our Sales team at 1-855-672-2710 and ask for this plan's Evidence of Coverage, or get a copy on our website at [hioscar.com/medicare/forms](https://hioscar.com/medicare/forms).

## Oscar + Holy Cross + Memorial Health (HMO)

Oscar + Holy Cross + Memorial Health (HMO) is an HMO plan with a Medicare contract. Enrollment in this plan depends on contract renewal. To be eligible, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day 7 days a week. TTY users should call 1-877-486-2048.

You must use our network providers to get covered services, except when you need emergency or urgently needed care or dialysis services. If you use the providers that are not in our network, we may not pay for these services.

This document is available in other formats.

For more information, please call us at 1-855-672-2710 (TTY users should call 711), or visit us at [www.hioscar.com/medicare](https://www.hioscar.com/medicare).

Learn more at [hioscar.com/medicare](https://hioscar.com/medicare)



# We make it easy and we give you more.

## Care Team

As an Oscar member, you have a Care Team of care guides and a nurse. You can call them at 1-855-672-2720 (TTY: 711), or message them any time through your online account or in the Oscar app. Your Care Team can schedule appointments, contact providers on your behalf for documents and authorizations, secure durable medical equipment, and answer any questions that you have about your plan.

Contact us 7 days a week from 8:00 a.m. to 8:00 p.m. local time from October 1st through March 31st, then on weekdays from 8:00 a.m. to 8:00 p.m. local time from April 1st through September 30th.



## Rewards & Incentives

Oscar's Onboarding Incentive Program encourages our members to connect with their Care Team and an assigned Primary Care Physician to make the most of their plan. You can get up to a \$100 gift card for completing activities when you first enroll<sup>1</sup> with Oscar, including an introductory call with your Care Team, selecting a PCP, completing a health risk assessment, and other welcome activities. Look out for a phone call from us shortly after you enroll in an Oscar plan to learn more.

<sup>1</sup>Not applicable to current Oscar members renewing a plan for 2021.

### Monthly plan premium, deductibles, and limits

Monthly plan premium	\$0 You must keep paying your Medicare Part B premium.
Medical deductible	\$0 This plan has no deductible.
Drug (Part D) deductible	\$0 This plan has no deductible.
Maximum Out-of-Pocket Responsibility (does not include Part D drugs)	\$3,400 This is the most you will pay for in-network Medicare covered services in copays and coinsurance. Once you reach this limit, we cover your medical costs for the rest of the year.

### Covered hospital, medical and supplemental benefits

Your Primary Care Physician (PCP) will oversee and coordinate your care, however you will **not** be required to obtain a referral prior to seeing specialists or other providers in the network. Certain services, procedures, and drugs below may require prior authorization (approval) from the plan.

Inpatient hospital	You pay \$0 per stay. Our plan covers unlimited additional hospital days.
Outpatient hospital	
Ambulatory Surgical Center (ASC)	\$75 copay
Outpatient hospital	\$100 copay for non-surgical services \$200 copay for surgical services
Doctor visits	
Primary Care Providers (PCP)	\$0 copay

Specialists	\$0 copay
Preventive care	
<p>Preventive care is very important for the future of your health. These services can help with the prevention and early detection of many illnesses, disabilities and diseases. Make sure to speak with your doctor about which preventive care services might be right for you so you can take the right steps to staying healthy.</p>	
Preventive care	<p>\$0 copay for preventive care services including, but not limited to:</p> <ul style="list-style-type: none"> <li>• Annual wellness visit</li> <li>• Bone mass measurements</li> <li>• Diabetes screenings</li> <li>• Colonoscopies</li> <li>• Flu shot</li> <li>• Mammograms</li> <li>• Pneumococcal vaccine</li> </ul>
<p>Any preventive services that are newly approved by Medicare during the plan year will also be covered. For the full list of preventive care services at no cost to you, please see the Evidence of Coverage (EOC).</p>	
Emergency and urgently needed services	
Emergency Care	<p>\$120 copay</p> <p>If you are admitted to the hospital within 24 hours for the same condition you were treated for in the ER, your cost for emergency services is waived.</p>
Urgent Care	<p>\$0 copay</p> <p>If you are admitted to the hospital within 24 hours for the same condition you were treated for in the urgent care setting, your cost for urgent care services is waived.</p>

Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures (ex: cardiac stress test)	<p>\$0 copay for Spirometry test for members with Chronic Obstructive Pulmonary Disorder and for removal of abnormal tissue and/or polyp(s) during a preventive colonoscopy</p> <p>\$5 copay for all other diagnostic tests and procedures</p>
Labs	\$0 copay
Diagnostic radiology (ex: MRIs, CT scans)	<p>\$0 copay for diagnostic mammograms and Dexa scans for anyone with a bone fracture</p> <p>\$50 copay for services performed in a provider's office or freestanding facility</p> <p>\$75 copay for services performed in an outpatient hospital</p>
X-rays	\$0 copay
Hearing	
Medicare covered hearing exams (ex: Diagnostic and balance evaluations)	\$0 copay
Supplemental hearing services	<p>\$0 copay for 1 routine hearing exam every year</p> <p>\$0 copay for 1 hearing aid fitting and evaluation every year</p> <p>\$2,000 towards the purchase of 2 hearing aids every year</p>
Our plan will provide you with a \$2,000 allowance to purchase 2 hearing aids every year. You will pay nothing unless you go over the allowance provided.	

Dental		
Supplemental dental services		
\$0 copay for the preventive (p) and comprehensive (c) services listed below. There is no maximum dollar limit on dental services every year.		
Service	Frequency	Example of service
Cleanings (p)	Once every six months	Prophylaxis
Exams (p)	Once every six months	Oral evaluation
X-rays (p)	Once every 12 to 36 months, depending on the procedure	Panoramic radiographic image
Fluoride treatments (p)	Once every year	Application of fluoride to build tooth enamel
Diagnostic services (c)	Once every year	Lab process of cultures
Restorative services (c)	Once every three years	Fillings
Service	Frequency	Example of service
Endodontics (c)	Once per tooth	Retreatment of previous root canal
Periodontics (c)	Once every 6 to 36 months, depending on the procedure	Scaling and root planning, which is the removal of plaque and tartar
Prosthodontics (c)	Once every 12 to 60 months, depending on the procedure	Dentures and crowns
Extractions (c)	Once per tooth	Removal of erupted tooth
Oral/Maxillofacial Surgery (c)	Once every 60 months or per lifetime, depending on the procedure	Removal of impacted tooth

Our plan has no maximum dollar limit on dental services every year. You will pay nothing for covered services.



## Vision

	\$0 copay for diabetic retinopathy eye exam
Medicare covered vision services	\$0 copay for all other Medicare covered eye exams
	\$0 copay for Medicare covered eyewear post cataract surgery
	\$0 copay for 1 routine vision exam every year
Supplemental vision services	\$300 towards the purchase of any combination of contact lenses, eyeglasses (frames and lenses), eyeglass frames only or eyeglass lenses only every year
	Contact lenses fitting and prescription sunglasses/tint are also covered

Our plan will provide you with a \$300 allowance for one or more pair of eyewear every year. You will pay nothing unless you go over the allowance provided.

## Mental Health Services

Inpatient	You pay \$400 per day for days 1 – 4. You pay \$0 per day for days 5 – 90.
Outpatient	\$15 copay for individual therapy \$15 copay for group therapy
Skilled Nursing Facility (SNF)	
	You pay \$0 per day for days 1 – 20. You pay \$184 per day for days 21 – 100.

Our plan covers up to 100 days in a SNF per benefit period. Your benefit period starts your first day in a SNF and it ends once you haven't received care from a SNF for 60 straight days.

Physical, Occupational, and Speech Therapy	
Physical and Speech therapy	\$15 copay
Occupational therapy	\$15 copay
Transportation	
Ambulance (ground & air)	\$200 copay
Supplemental transportation	\$0 copay
Our plan covers unlimited transportation to plan-approved health-related locations. These locations include, but are not limited to: physician offices, pharmacies, and fitness centers in the plan's network.	
Medicare Part B Drugs	
Chemotherapy drugs	20% coinsurance
Other Part B drugs	20% coinsurance

## Prescription drug (Part D) benefits

There are four stages of your Part D benefit. What you pay for your drugs can depend on the stage you are in at the time you pick them up from the pharmacy and if that pharmacy is in our network.

You can get your covered drugs at our network pharmacies, including retail and mail order pharmacies. You can only get your drugs from out-of-network pharmacies when in-network pharmacies are unavailable. If you use a pharmacy that is not in our network, you may pay more than listed below.

### Stage 1: Drug (Part D) deductible

\$0

This plan has no deductible.

This stage does not apply to this plan since there is no deductible. This means you start paying the costs described below starting on your first day with the plan.

### Stage 2: Initial coverage stage

Retail and Mail Order cost shares (in-network)	One-month supply	Three-month supply
Tier 1 (Preferred generic)	\$0	\$0
Tier 2 (Generic)	\$0	\$0
Tier 3 (Preferred brand)	\$30	\$90
Tier 4 (Non-preferred drug)	\$75	\$225
Tier 5 (Specialty)	33%	N/A

You pay the above amounts until your total yearly drug costs reach **\$4,130**. Drug costs that you and your plan pay for your prescription drugs contribute to this amount. Once you reach this amount, you will move on to the next stage of the benefit.

If you get prescriptions from a long-term care pharmacy, you pay the same cost-shares for a one-month supply as you would in a retail pharmacy.

### **Additional drug coverage.**

We cover up to 6 pills per month (a maximum of 73 pills a year) of Sildenafil, a generic version of Viagra, as a Tier 2 medication.

### Stage 3: Coverage gap (donut hole)

#### **Our plan provides extra drug coverage in the coverage gap stage.**

Cost sharing for a 30-day supply at a network retail or mail order pharmacy:

- Tier 1: \$0
- Tier 2: \$0

You pay 25% of the cost of generic and brand drugs during this stage. You must pay these amounts until your total out-of-pocket costs reach \$6,550. This amount is set by Medicare each year. Once you reach this amount, you will move on to the next stage of the benefit. Most people never reach the coverage gap.

### Stage 4: Catastrophic stage

Once you reach this stage, you pay the greater of:

- 5% of the cost; or
- \$3.70 copay for generic drugs and \$9.20 for brand drugs

### **Additional benefits**

#### Telehealth services

\$0 copay for the following types of services when they are provided using standard telehealth methods, such as video remote imaging: urgent care, PCP, other healthcare professionals such as nurse practitioners and individual sessions for outpatient mental health services, psychiatric services, and outpatient substance abuse services.

Our plan allows you to get the services listed above either in-person or via telehealth methods like telephone and video remote imaging. In other words, the same services available via telehealth are also available in person, though your cost-share amount may be different.

Diabetic supplies	\$0 copay for Medicare-covered diabetic monitoring supplies.
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Roche Diabetes Care is our exclusive diabetic supply manufacturer. We only cover monitors, test strips, and lancets manufactured by Roche Diabetes Care.

You may use any of the following glucose monitors that are manufactured by Roche Diabetes Care:	<ul style="list-style-type: none"> <li>• Accu-Chek Aviva Plus Care Kit</li> <li>• Accu-Chek Guide Care Kit</li> <li>• Accu-Chek Nano SmartView Care Kit</li> </ul>
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Prior authorization is required in excess of 2 glucose monitors a year and/or more than 150 test strips every 25 days. If you currently use supplies made by another manufacturer, speak with your doctor about switching to Roche products.

### Additional supplemental benefits

Over-the-counter (OTC)	\$100 every three months for the purchase of OTC items
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Our plan will provide you with a card loaded with the dollar amount noted above every three months. You can use this card to purchase OTC items such as cold and allergy medicine, vitamins, and personal care items from a national network of retailers. If you can't get to the store, you will have to option to get items mailed to you at no extra cost.

Fitness – Silver & Fit	\$0 copay
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Our plan will provide you with access to a national network of fitness centers so you can get or stay healthy. If you can't make it to a fitness center, our plan will provide fitness kits that are shipped to you at no extra cost. A Fitbit fitness tracker is included in one of the home kit options.

Meals	\$0 copay
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Our plan will provide you with home-delivered meals right after surgery or an inpatient hospital stay to aid in your recovery. You will receive 2 meals a day for 7 days, with a maximum 14 meals total.

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Supplemental  
Acupuncture and  
Chiropractic services

\$0 copay

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Our plan will provide 20 visits per year combined between both acupuncture and chiropractic services. You can choose to use the combination of these services as you wish.

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Worldwide emergency (ER)/  
Urgent care services

\$120 copay

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Our plan covers up to \$25,000 maximum for emergency and urgent care services received outside of the U.S. and it's territories.

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Additional annual physical

\$0 copay

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 855-672-2710 (TTY: 711).

## Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit [www.hioscar.com/medicare/forms](http://www.hioscar.com/medicare/forms) or call 855-672-2710 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/coinsurance may change on January 1, 2022.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Oscar is an HMO with a Medicare contract. Enrollment in Oscar depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 855-672-2720 (TTY: 711).



# Disclaimers

## ATTENTION

Oscar is an HMO with a Medicare contract. Enrollment in Oscar depends on contract renewal. **ATTENTION:** If you speak Spanish, language assistance services, free of charge, are available to you. Call 855672-2720 (TTY: 711). Out-of-network/noncontracted providers are under no obligation to treat members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information. Other providers are available in our network.

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